MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 196 E. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Walter Abalaweh

3. (b) Social Security Number: 216-09-3655

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1898

8. AGE: Years	Months	Days	If less than one day
48	9	25	hrs. min.

9. Birthplace: Daneva, Kitovistki, Lithuania
(Town, county, and state)
10. Usual occupation: Shoe worker
11. Industry or business

FATHER
12. Name: Not known
13. Birthplace: " "

MOTHER
14. Maiden name: " "
15. Birthplace: " "

16. Informant: Mrs. J. M. Meredith
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4/7/47 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 4/7 19 47 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 (last) 19 47, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
(a) Probably Coronary Occlusion	Few minutes
Due to: Hypertension and cardiovascular disease	3 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: V. J. Billingsley, M. D.
acting Deputy Med. Examiner M. D. or other
Address: Westminster, Md. Date signed: 4-6-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06850

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jacob E. Anders

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of ~~husband~~ or wife: late Ida Mae Anders
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 18 - 1874

8. AGE: Years: 73 | Months: 2 | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick County, Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: Michael Anders
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Hartman
15. Birthplace: Maryland

16. Informant: Miss Fannie Hauck
Address: Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 - 1947 (month) (day) (year)
Cemetery or crematory: Mt Hope Cemetery
Location: Woodsboro, Md

18. Funeral director: C. W. Hartley & Sons
Address: Union Bridge & New Windsor, Md

19. April 5, 1947 (Date rec'd by registrar) E Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3, 1947, at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1947, to April 3 1947 and that I last saw h.. alive on April 3 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. N. Legg, M. D. or other
Address: Union Bridge Date signed: 4-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-1)

00851

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 2 mos

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alice Virginia Armentrout

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: General Kemper Armentrout

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 14 1864

8. AGE: Years: 82 Months: 8 Days: 30 If less than one day: hrs. min.

9. Birthplace: Carroll County. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Daniel Miller

13. Birthplace: Carroll Co

MOTHER — 14. Maiden name: Rebecca Wantz

15. Birthplace: Carroll Co

16. Informant: Gen'l Kemper Armentrout

Address: R.F.D. #3 Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 16-1947 (month) (day) (year)

Cemetery or crematory: Westminster Cem.

Location: Westminster, Md.

18. Funeral director: H. Bankard & Son

Address: Westminster, Md.

19. Apr. 14 1947 C. Harry Zile Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1947, at 11-20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr 13 1947, to April 13 1947 and that I last saw her alive on April 13th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 yrs
Due to: Hard Arterio Sclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Wastun M.D. M. D. or other

Address: Sykesville Md. Date signed: 4/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64c)

CERTIFICATE OF DEATH

06852

Reg. Diat. No. 74 43

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Woodbine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural - Woodbine

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Woodbine Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Gertrude Velma Atkinson

3. (b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Leslie Atkinson

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1910

8. AGE:

Years	Months	Days	If less than one day
36	6	7	hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Kaleb Johnson

13. Birthplace: Md.

MOTHER 14. Maiden name: Elizabeth Wall

15. Birthplace: Md.

16. Informant: Mr. Leslie Atkinson

Address: Woodbine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-19-47 (month) (day) (year)

Cemetery or crematory: Mt View Cemetery

Location: Howard Co., Md.

18. Funeral director: C. Harry Ware

Address: Sykesville, Md.

19. April 18 1947 C. Harry Ware

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1947 at 12:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19....

and that I last saw h ..... alive on ..... 19....

Immediate cause of death	DURATION
Gunshot wounds of head	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: Apr. 17-47

Where did injury occur? Woodbine (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Gunshot Wound in head Injured at work? No.

23. SIGNATURE: James T. Mond Deputy Medical Examiner M. D. or other

Address: Westminster Md. Date signed 4-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(94a)

06853

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: J. Wilmer Baker

3.(b) Social Security Number: None

4. Sex: male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of ~~husband or~~ wife: Maybelle Rinehart Baker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 16 - 1901

8. AGE: Years: 45 | Months: 8 | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County Md

(Town, county, and state)

10. Usual occupation: Postmaster

11. Industry or business:

FATHER

12. Name: Joseph A. Baker

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Watt

15. Birthplace: Maryland

16. Informant: Maybelle R. Baker

Address: Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29-1947 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: W. H. Hartzler & Sons

Address: Union Bridge & New Windsor, Md

19. April 29 1947 (Date rec'd by registrar) L. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1947, at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946, to April 26 1947

and that I last saw him alive on April 25 1947

Immediate cause of death: Coronary occlusion

Due to: Coronary disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Wilmer Baker M. D. or other

Address: Westminster Md Date signed: Apr 26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00854

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-4)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 90 Park Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME: ELLA COPES BLACK

3.(b) Social Security Number: 219-07-5742

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: John W. Black
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): December 16, 1914

8. AGE: Years	Months	Days	If less than one day
32	4	7	....hrs. ....min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business

FATHER
12. Name: Jessie Copes
13. Birthplace: Virginia

MOTHER
14. Maiden name: Eva Tull
15. Birthplace: Virginia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 25/47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Cambridge, Md.
18. Funeral director: Lewis H. Staunton
Address: Cambridge, Md.

19. 4/23 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23, 19 47 at 7.40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 23, 19 46 to April 23, 19 47 and that I last saw her alive on April 23, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 27 1946
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Norbert W. Braun, M.D. M. D. or other
Address: Henryton, Md. Date signed 4/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-46 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06855

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Mt Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town near Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Henry Black

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Laura V. Black
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): April - 12 - 1878

8. AGE:

Years	Months	Days	If less than one day
69	0	14	hrs. min.

9. Birthplace: Maryland Carroll Co.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Henry Black
13. Birthplace: Germa.
MOTHER 14. Maiden name: Francaina Gummrine
15. Birthplace: Maryland
16. Informant: George H. Black Jr.
Address: Manchester Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-30-47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Winkis Sons
Address: Manchester. Md.
19. Apr. 30 1947 Mrs. W. R. S. Demmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1947 at 10:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: James T. Ward Deputy Medical Examiner
M. D. or other
Address Westminster Md Date signed Apr. 26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

CERTIFICATE OF DEATH

Reg. Dist. No. 76

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Carroll Co.
City or town near Westminster Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 3 mo.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. New London Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Allen Blockston

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3. 1946

8. AGE: Years 0 | Months 8 | Days 29 | If less than one day hrs. min.

9. Birthplace Baltimore City Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name James H. Blockston Jr.
13. Birthplace Riverside N.J.

MOTHER 14. Maiden name Katie Mae Masters
15. Birthplace Rosedale, Okla.

16. Informant Mrs. Katie Mae Masters Blockston
Address Westminster Md. R.D. #5

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 47 (month) (day) (year)
Cemetery or crematory Meadow Branch Cem.
Location Rural near Westminster, Md.

18. Funeral director J. E. Myers Jr.
Address Westminster Md.

19. 4/4/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947, at 1 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1947, to April 2 1947
and that I last saw h... alive on April 2 1947

Immediate cause of death	DURATION
Pneumococcemia	24 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Moore M. D. or other
Address Westminster Md Date signed 4/3/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3rd)

CERTIFICATE OF DEATH

00857

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 21 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Poolesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: William Bodmer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Ella Smith

6.(c) If alive, give age: Dec. years

7. Birth date of deceased (mo., day, yr.): 3/4/1863

8. AGE: Years	Months	Days	If less than one day
84	11	2	...hrs. ...min.

9. Birthplace: Alexandria, Virginia
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Jacob Bodmer
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Lantz
15. Birthplace: Germany

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 8, 1947 (month) (day) (year)

Cemetery or crematory: Middleburg

Location: Middleburg, Va.

18. Funeral director: Wm. B. Hilton

Address: Barnesville, Md.

19. Apr. 9 1947 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/6 1947, at 9:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/15/ 1947, to 4/6/ 1947

and that I last saw h... im ...alive on 4/6 1947

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Unknown
Chronic myocarditis	
Due to	
Due to	
Other conditions: Senile Psychosis	8 mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Joseph H. Marshall Jr. M.D.
M.D. or other

Address: Sykesville, Maryland Date signed: 4/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

06858

Reg. Diat. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 19 Chase St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Henry Edward Bonner

3.(b) Social Security Number: 212-24-2935

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Eva M. Bonner

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): October 3, 1885

8. AGE: Years	Months	Days	If less than one day
61	6	13	....hrs. ....min.

9. Birthplace: Houcksville, Carroll Co., Md. (Town, county, and state)

10. Usual occupation: retail grocer (retired)

11. Industry or business

FATHER — 12. Name: Edward A. Bonner

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lydia A. Houck

15. Birthplace: Maryland

16. Informant: Mrs. Eva M. Bonner

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4/18/47 (month) (day) (year)

Cemetery or crematory: Calvary Cemetery

Location: near Finksburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 4/17/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1947, at 3 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 10 1945 to April 16 1947 and that I last saw h.. alive on April 16 1947

Immediate cause of death	DURATION
Acute Coronary Occlusion	10 minutes
Due to	
Due to	
Other conditions Chronic Coronary Disease	2 years

(Incinde pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hunter Bonner M.D. M. D. or other

Address: Westminster, Md. Date signed 4/16/47

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-4 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

00859

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County Carroll

City or town Manchester R. D. 1 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs

Hospital, institution, or street address where death occurred: Manchester District

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Manchester (If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. 1 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Isaac Winfield Bortner

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Lucinda Bortner

6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) April - 3 - 1870

8. AGE: Years 77 Months 0 Days 26 If less than one day ... hrs. ... min.

9. Birthplace York County, PA (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Farming (Retired)

FATHER 12. Name Esrom Bortner

13. Birthplace York County, PA

MOTHER 14. Maiden name Sarah Bankert

15. Birthplace York County, PA

16. Informant Louie G. Bortner

Address Manchester, Md. R. D. 1

17. Burial (Burial, cremation, or removal, Which?) Date thereof May 2 - 1947 (month) (day) (year)

Cemetery or crematory Black Rock Brethern Cemetery

Location York County, PA

18. Funeral director J. W. Little & Son

Address Littlestown, PA. Pa R A State

19. May 29 1947 MRS. W. R. S. Denner (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947, at 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1945 to Apr 29 1947

and that I last saw him alive on April 28 1947

Immediate cause of death Cerebral Hemorrhage — DURATION 4 Da

Due to Arterio-Sclerotic, Cardio Renal Vascular Disease ?

Due to

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? —

23. SIGNATURE Joseph E. Bush M.D. M. D. or other

Address Hampstead Md. Date signed 4-29-47

Evidence for change of birthdate shown on:

FILM No. G 11 C MAY 12 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

06860

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster R.D. 5

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Warfieldsburg

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hennings

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Hershey Brown

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Ida Jones Brown

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 7 1866 1867

8. AGE: Years	Months	Days	If less than one day
79	10	9	..... hrs. ..... min.

9. Birthplace: Frederick County (Town, county, and state)

10. Usual occupation: Retired Auctioneer

11. Industry or business

FATHER — 12. Name: Andrew Brown

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Peters

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Ida Jones Brown

Address: Westminster R.D. 5 - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19 1947 (month) (day) (year)

Cemetery or crematory: Sams Creek Cemetery

Location: near New Windsor

18. Funeral director: D.D. Hartsler & Sons

Address: New Windsor & Union Bridge, Md.

19. 4/17 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1947, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6th 1947, to Apr. 16th 1947 and that I last saw him alive on April 16th 1947

	DURATION
Immediate cause of death: Chronic myocarditis	3 yrs ?
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. H. Billingslea M. D. or other

Address: Westminster, Md. Date signed 4-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06861

Reg. Diat. No. 191

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 17 days.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 mos., 17 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)

Street No. -----
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: WILLIAM GRANT COLLINS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed.

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 7, 1867

8. AGE: Years	Months	Days	If less than one day
79	9	30	..... hrs. ..... min.

9. Birthplace: Delaware
(Town, county, and state)

10. Usual occupation: Storekeeper

11. Industry or business: -----

FATHER 12. Name: John B. Collins

13. Birthplace: unknkown

MOTHER 14. Maiden name: Elizabeth Moore

15. Birthplace: unknown

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-8-47 (month) (day) (year)

Cemetery or crematory: Hebron

Location: Hebron Md.

18. Funeral director: David K. Messick

Address: Hebron Md

19. April 5, 1947 (Date rec'd by registrar) John B. Leighton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5, 1947, at 11:10P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20, 1946, 19..., to April 5, 1947, and that I last saw him alive on April 5, 1947.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1½ yrs.
Due to	
Due to	
Other conditions: Senile Psychosis, Simple Deterioration (Include pregnancy within 3 months of death)	6 mos.

Major findings of operation: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: Springfield State Hospital Sykesville, Md. Date signed 4-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate if age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

06862

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 112 N. Bond Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GEORGE COLLISON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March ?, 1912

8. AGE:

Years	Months	Days	If less than one day
35	0	?	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Henry Collison
13. Birthplace: St. Mary's Co., Md.

MOTHER
14. Maiden name: Bessie (Unknown)
15. Birthplace: King & Queen Co. Va.

18. Informant: Ella Bennett
Address: 539 N. Bond St. Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12-1947 (month) (day) (year)
Cemetery or crematory: Int. Calvary Cemetery
Location: A. A. Co., Md.
18. Funeral director: Robt. E. Williams
Address: 1515 McElderry St.

19. 4/9 (Date rec'd by registrar) 19 47 Albert L. Smithhammer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9, 1947 at 9.10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24, 1947 to April 9, 1947 and that I last saw him alive on April 9, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 2 1942
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Offman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 4/9/47

06863

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 5M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 2 mo's., 26 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1387 Woodyear Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JUANITA VIRGINIA CORNISH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 22, 1932

8. AGE:

Years	Months	Days	If less than one day
15	2	21	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER 12. Name: Frederick Cornish

13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Lillian Schools

15. Birthplace: Essex County, Va.

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 17-1947 (month) (day) (year)

Cemetery or crematory: Arbutus Park

Location: Arbutus,

18. Funeral director: Wm Brooks Ruggold

Address: 1463 N. Carey St

19. 4/13 19 47 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 19 47, at 500 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan., 18, 19 45 to April 13, 19 47 and that I last saw h er alive on April 13, 19 47

Immediate cause of death: Pulmonary Tuberculosos — DURATION: Dec. 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben A. Fuman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 4/13/47

06864

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-L)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 241 E. Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret Elizabeth Crist

3.(b) Social Security Number 216-14-6735

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Edward F. Crist
6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Nov. 25 - 1908

8. AGE: Years	Months	Days	If less than one day
38	5	5	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John A. Myers
13. Birthplace Md.
MOTHER 14. Maiden name Lillie I. Hollenbaugh
15. Birthplace Md.
16. Informant Elizabeth Crist
Address 241 E. Green St. Westminster, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof May 2 - 1947 (month) (day) (year)
Cemetery or crematory Meadowbranch Cemetery
Location Westminster, Md.
18. Funeral director H. Bankard Son
Address Westminster, Md.
19. 5/1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 - 1947, at 11:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to April 30 1947
and that I last saw h[illegible] alive on April 29 - 1947

Immediate cause of death	DURATION
Carcinoma Uterus (Penis)	
Carcinoma Liver	
Due to Carcinoma Brain	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D.
M. D. or other
Address Westminster Date signed 3-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00865

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 10 mon., 7 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yrs., 10 mon., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Vernon A. Dailey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 24, 1902

8. AGE: Years	Months	Days	If less than one day
44	9	4	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: William Dailey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Catherine Conway
15. Birthplace: Maryland

16. Informant: Springfield State Hospital records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-1-47 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Balto. Md.
18. Funeral director: Klymyst & Fleming
Address: 1426 Light St. Balto. Md.

19. Apr. 29 1947 C. Harry Elwes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1947 at 6:25A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to April 28 1947
and that I last saw him alive on April 27 1947

Immediate cause of death	DURATION
Coronary occlusion	instant
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May, M.D. M. D. or other
Springfield State Hospital
Address: Sykesville, Maryland Date signed: 4-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45

Evidence for the change of date of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

FILM NO. G 11 C MAY 6 1947 **CERTIFICATE OF DEATH**

06866

Reg. Dist. No. 7H

1. PLACE OF DEATH:
County Carroll
City or town Oakland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Oakland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dorothy M. Day

3.(b) Social Security Number 217-18-8570

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 1923 1922

8. AGE: Years	Months	Days	If less than one day
24	8	7	hrs. min.

9. Birthplace Carroll Co.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John L Day
13. Birthplace Howard Co

MOTHER
14. Maiden name Eliza A Edmondson
15. Birthplace Carroll Co.

16. Informant John L Day
Address Oakland Carroll Co

17. Burial Date thereof April 14 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Providence Cemetery
Location Carroll Co.

18. Funeral director J F Elmer & Sons
Address Westminster Md.

19. April 11 1947 C. Harvey Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 10 a M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 7 1947 to April 11, 1947 and that I last saw h.e.r alive on April 10, 1947

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Tom E. Martin M. D. or other
Address Randallstown, Md. Date signed 4/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06867

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 26 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 558 Gold Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LITCHFIELD DILIVER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6, 1900

8. AGE:

Years	Months	Days	If less than one day
46	11	14	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Shadrick Diliver
13. Birthplace: Virginia
MOTHER 14. Maiden name: Unknown
15. Birthplace: Virginia
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/23/47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County.
18. Funeral director: Geo. G. Kelton
Address: 1303 Pennsylvania Ave.
19. 4/20 19 47 (Date rec'd by registrar) Albert R. Somerville Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 19 47 at 2.10P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb., 25, 19 47, to April 20, 19 47 and that I last saw him alive on April 20, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 4/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

00868 P 74

Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 7 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 197 East Green Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: DORA SUSAN EDWARDS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Henry Alexander Edwards
6.(c) If alive, give age: Dec. years

7. Birth date of deceased (mo., day, yr.): April 8, 1854

8. AGE: Years	Months	Days	If less than one day
92	11	27	hrs. min.

9. Birthplace: Union County, West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John McCormick
13. Birthplace: Rockingham County, Virginia
MOTHER 14. Maiden name: J. Sarah Agnes Alford,
15. Birthplace: Petersburg, West Virginia
16. Informant: Son: J. B. Edwards,
Address: 241 W. Lanvale St. Baltimore-17, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4/8/47 (month) (day) (year)
Cemetery or crematory: Rock Creek Cem.
Location: Washington, D. C.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 4-7-47 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 19 47 at 7:10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/28 19 46 to 4/5 19 47 and that I last saw h 34 alive on 4/5/ 19 47

Immediate cause of death	DURATION
Bronchopneumonia	24 hours
Due to: Chronic hypertension	unknown
Due to: Generalized Arteriosclerosis	unknown
Other conditions: Senile Psychosis, Simple Deterioration	9 yrs. ago

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other
Address: Sykesville, Maryland Date signed: 4/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-b)

CERTIFICATE OF DEATH

06869

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 years, 8 months, 25 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 41 years, 8 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 729 George Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha V. Eichelberger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown 1882

8. AGE: Years	Months	Days	If less than one day
65	?	?	hrs. min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: J. F. Eichelberger
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary V. Forman
15. Birthplace: Maryland

16. Informant: Records, Springfield State Hospital
Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-30-47 (month) (day) (year)
Cemetery or crematory:
Location: Frederick, Md.

18. Funeral director: M. R. Etchison & Son
Address: Frederick, Md.

19. April 30 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/30 1947, at 12:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1925 to 4/30/ 1947 and that I last saw her alive on 4/29 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 weeks
Pulmonary Tuberculosis	47 years
Due to:	
Due to:	
Other conditions: Schizophrenia, catatonic type, acute, imbecility	47 years

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall M. D. or other
Address: Sykesville, Maryland Date signed: 4/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00870

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 567 Dolphin Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HELEN EVANS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife: Joseph Evans
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 3, 1922

8. AGE: Years	Months	Days	If less than one day
24	4	14	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Walter Brown
13. Birthplace: Maryland

MOTHER
14. Maiden name: Isabell Jones
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/22/47 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem
Location: Baltimore Md
18. Funeral director: Mc Geo J Holland
Address: 1631 Druid Hill Ave

19. 4/17 (Date rec'd by registrar) 19 47 Albert R. Swandby Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17, 19 47 at 12.10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan., 20, 19 47 to April 17 19 47 and that I last saw her alive on April 17, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W Kenan, M.D. M. D. or other
Address: Henryton, Md. Date signed 4/17/47

VS-A15 9-45 M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(946)

00871

CERTIFICATE OF DEATH

Reg. Diat. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lela Clay Garber

3.(b) Social Security Number: None

4. Sex: female | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: Edward Garber
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 17 - 1879

8. AGE: Years: 67 | Months: 8 | Days: 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Charles Repp
13. Birthplace: Maryland

MOTHER
14. Maiden name: Adora Ngill
15. Birthplace: Maryland

16. Informant: Mrs. Jobie Weller
Address: Uniontown, Md.

17. Burial (Burial, cremation, or removal) Which?) Date thereof May 3 - 1947 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Uniontown Road

18. Funeral director: H. D. Hartley & Sons
Union Bridge & New Windsor, Md.

19. May 2, 1947 (Date rec'd by registrar) Margaret R. England Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1947 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 30 1947 to April 30 1947
and that I last saw h.. alive on April 30 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. Mason M.D.
M. D. or other
Address: Johnsville Date signed May 4 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00872

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-47

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 28 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Minnie B. Gerstmeyer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 19, 1880

8. AGE: Years	Months	Days	If less than one day
66	8	17	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Louis Gerstmeyer
13. Birthplace: Germany
MOTHER 14. Maiden name: Sophia Bielstein
15. Birthplace: Germany
16. Informant: Hospital records
Address: Springfield State Hospital
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-8-47 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Balto. Md.
18. Funeral director: Snyder Funeral Home
Address: 1602 W. North Ave. Balto. Md.
19. April 5 19 47 C. Henry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5, 1947 at 4:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1942 to April 5, 1947 and that I last saw her alive on April 4, 1947

Immediate cause of death	DURATION
coronary occlusion	24 hours
Due to (disease of the coronary arteries)	
Due to	
Due to	
Other conditions: Schizophrenia, hebephrenic type	about 40 years

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene H Hakmen M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 4-5-47

00873

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Diat. No 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Andrew J. Gorman

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Emily P. Gorman
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1869

8. AGE: Years: 77 | Months: 8 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Blacksmith
FATHER 12. Name: John Gorman
FATHER 13. Birthplace: Scotland
MOTHER 14. Maiden name: Miranda Shipley
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. Emily P. Gorman
Address: Manchester, Md.
17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 4-27-47 (month) (day) (year)
Cemetery ~~or crematory~~: Prospect
Location: Mt. Airy, Maryland
18. Funeral director: C. M. Waltz
Address: Winfield, Md.
19. April 27 1947 Mrs. W. P. S. Benner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1947, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31st 1947, to April 25th 1947 and that I last saw h~~im~~ alive on April 24th 1947

Immediate cause of death	DURATION
Arterio Sclerosis + Hypertension	2 yrs.
Due to: Senescence or age	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr D. M Resh M. D. or other
Address: Hampstead Md. Date signed 7/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 872

CERTIFICATE OF DEATH

00874 B

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs. 9 mon. 22 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 15 yrs. 9 mon. 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: George C. Hatch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10, 1878

8. AGE: Years	Months	Days	If less than one day
68	10	21	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer and cook

11. Industry or business:

FATHER 12. Name: Alfred C. Hatch

FATHER 13. Birthplace: Baltimore, Maryland

MOTHER 14. Maiden name: Ella Cummings

MOTHER 15. Birthplace: Washington, D.C.

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/3/47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Baltimore, Md.

18. Funeral director: John Burns' Sons

Address: Towson, Md.

19. April 2 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1, 1947 at 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943 to April 1, 1947 and that I last saw him alive on March 31, 1947

Immediate cause of death	DURATION
Huntington's chorea	15 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D. M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 4/1/47

VS-A15 9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06875

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 3 months
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 years, 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: IDA MARGARET HATHAWAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 12, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	28	hrs. min.

9. Birthplace: Rochester, New York
(Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER
12. Name: John Vickers
13. Birthplace: England

MOTHER
14. Maiden name: Louise Rego
15. Birthplace: France

16. Informant: Hospital records
Address: Springfield State Hospital

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 4/14/47 (month) (day) (year)
Cemetery or crematory: Cremation London Park.
Location: Frederick Road.
18. Funeral director: Howard M. Blight Jr.
Address: 6009 Ballard Road.

19. April 14 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1947, at 3:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 1943, to April 11 1947 and that I last saw her alive on April 10, 1947

Immediate cause of death		DURATION
Chronic myocarditis and myocardial degeneration	about	2 years
Due to: Arteriosclerosis	about	4 years
Due to:		
Other conditions: Senile psychosis, simple deterioration (Include pregnancy within 3 months of death)	about	4 years

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene H. Lehmann, M.D. (M. D. or other)
Address: Springfield State Hospital Date signed: 4-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

00876

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yr., 7 mo., 1 day
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 27 yr., 7 mo., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Unk (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: 1

3.(a) FULL NAME: John Heiss

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1884

8. AGE: Years	Months	Days	If less than one day
63	--	2	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: agriculture
FATHER 12. Name: John Heiss
13. Birthplace: Holland
MOTHER 14. Maiden name: Margaret Samuels
15. Birthplace: Holland
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-18-47 (month) (day) (year)
Cemetery or crematory: Springfield State Hosp. Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19 April 18, 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 1947, at 3:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to April 12, 1947 and that I last saw him alive on April 11, 1947

Immediate cause of death	DURATION
Coronary occlusion	instant
Due to:	
Due to:	
Other conditions: Psychosis with Mental Deficiency	28 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D. M. D. or other
Address: Springfield State Hospital Sykesville, Maryland Date signed: 4-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45

00877

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 20 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 810 Leadenhall Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES THOMAS HIGHTOWER

3.(b) Social Security Number: 213-01-4443

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Katie Hightower
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): March 19, 1893

8. AGE: Years	Months	Days	If less than one day
54	0	27	hrs. min.

9. Birthplace: South Boston, Va.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Thomas Hightower
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Deceased
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 18 47 (month) (day) (year)
Cemetery or crematory
Location: Halifax County, Va
18. Funeral director: Isaac L Brown Son
Address: 1080 Montgomery Street
19. 4/15 19 47 (Date rec'd by registrar) Albert L Brown Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1947, at 9.05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1945, to April 15, 1947 and that I last saw h im alive on April 15, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 4/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

06878

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 12 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: rural near Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Edward Hillyard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Janet Golightly
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): November 21, 1873

8. AGE: Years	Months	Days	If less than one day
73	5	2	..... hrs. ..... min.

9. Birthplace: Frederick County, Virginia
(Town, county, and state)
10. Usual occupation: farmer
11. Industry or business: agriculture

FATHER
12. Name: Jacob Hillyard
13. Birthplace: Virginia

MOTHER
14. Maiden name: Frances Lee
15. Birthplace: Virginia

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-24-47 (month) (day) (year)
Cemetery or crematory:
Location: 517-11th St. S.E. Wash D.C.
18. Funeral director: W. W. Chambers Co.
Address: 517-11th St. S.E. Wash D.C.
19. Apr. 24 1947 (Date rec'd by registrar) C. Harvey Ellis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1947 at 5:30a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1947 to April 23 1947 and that I last saw him alive on April 22 1947

Immediate cause of death	DURATION
Coronary occlusion	instant
Due to:	
Due to:	
Other conditions: Senile psychosis, simple deterioration	5 years

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.: .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ..... Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D. or other
Address: Springfield State Hospital Sykesville, Maryland
Date signed: 4-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

00879

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Rural near Carrollton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Most of her life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Carrollton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: About 5 Miles South of Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ada Alberta Houck

3.(b) Social Security Number: —

4. Sex: f.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Jacob Houck
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 5, 1874

8. AGE: Years: 72 Months: 7 Days: 6 If less than one day ... hrs. ... min.

9. Birthplace: Shiloh, Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: House-wife
11. Industry or business

FATHER
12. Name: Francis Thomas Stone
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Jane Wooley
15. Birthplace: Maryland

16. Informant: Mr. Lester A. Houck
Address: Westminster, Md, R-D #4
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 14, 47 (month) (day) (year)
Cemetery or crematory: Wesley Cemetery
Location: Near Hampstead, Md.
18. Funeral director: J. S. Myers Jr.
Address: Westminster Md.
19. 4/12 1947 [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1947 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Cerebral Hemorrhage
Generalized Arterio-Sclerosis
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations —
Date of op. —
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work? —

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other
Address: Westminster Md. Date signed: 4-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06880

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years, 3 months

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 13 years, 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret J. House

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown House

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1872

8. AGE: Years	Months	Days	If less than one day
74	10	14	hrs. min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER
12. Name: Lewis Guilbert
13. Birthplace: unknown

MOTHER
14. Maiden name: Magiline Bumgardner
15. Birthplace: unknown

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 7, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Frederick Md.

18. Funeral director: John G. Moran

Address: 3006 E. Baltimore St. Balt. Md.

19. Apr. 2 1947 (Date rec'd by registrar) Stanley Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1947 at 11.15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1942 to April 2, 1947 and that I last saw her alive on April 2, 1947

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	about 3 years
Due to: fracture of neck of femur	4 months
Due to: Accidental fall. Patient slipped and fell while walking to her bed. Cwb.	
Other conditions: schizophrenia, paranoid type	about 15 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident. Date of November 25, 1946.

Where did injury occur? Springfield State Hospital. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Dormitory of Cottage F.

Means of injury: Injured at work?

23. SIGNATURE: Irene Hitchman, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 4-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1-35

00881

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING (I) VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster Route 5
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 5.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Laura A. Iglehart

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Tilghman H. Iglehart
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 12, 1873

8. AGE: Years	Months	Days	If less than one day
74	3	18	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Alfred Belt
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Hildebrand
15. Birthplace: Maryland

16. Informant: Goerge G. Roberts
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5/3/47 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Pikesville, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 5/2 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 19 47 at 10.15 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 20th 19 47, to April 30 19 47 and that I last saw her alive on April 30th 19 47

Immediate cause of death	DURATION
Hypostatic Pneumonea -	3 days
Due to Fracture left Ankle -	10 days.
Due to Accidental fall. Senile.	
Other conditions Diabetes Mellitus	8 years.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of: March 15th. 1947.
Where did injury occur? Westminster Route 5. (City or town) Carroll. (County) Maryland. (State)
Injured at home, farm, industry, public place (where?): Bedroom of her home.
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Westminster - Md. Date signed: 5/1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06882

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46 5M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 6 mo's, 11 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 433 N. Durham Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CARRIE MAE JONES

3.(b) Social Security Number: 214-22-7279

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Louis Jones
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): July 4, 1916

8. AGE:

Years	Months	Days	If less than one day
30	9	10	....hrs. ....min.

9. Birthplace: Broadneck, Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Aussie Hawkins
13. Birthplace: Broadneck, Va.

MOTHER
14. Maiden name: Pearl Green
15. Birthplace: North Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/17/47 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Baltimore County Md
18. Funeral director: Joseph B. Locke, Jr.
Address: 1304 N. Central Ave

19. 4/14 (Date rec'd by registrar) 19 47 Albert R. Newman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14, 1947 at 10.55A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3, 1945 to April 14, 1947 and that I last saw her alive on April 14, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Kwan, M.D.
M. D. or other
Address: Henryton, Md. Date signed 4/14/47

00883

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3714 Fait Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Germanus Kalbfleisch

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ella Kalbfleisch
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 12/28/1890

8. AGE: Years	Months	Days	If less than one day
56	3	13	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business
FATHER 12. Name: John H. Kalbfleisch
13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Theresa Grieser
15. Birthplace: Baltimore, Maryland
16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-15-47 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cem.
Location: Balto. Md.
18. Funeral director: Lilly & Zeiler, Inc.
Address: 403 N. Wolfe St.
19. Apr 12 1947 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/11 19 47 at 2:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/14 19 47, to 4/11 19 47
and that I last saw h... im alive on 4/11 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions: Schizophrenia, paranoid type	5 Yrs. ?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M/D, or other
Address: Sykesville, Maryland Date signed 4/11/47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B

00884

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since May 21, 1929
Hospital, Institution, or street address where death occurred: Springfield State
How long in hospital or institution? since May 21, 1929

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balt.
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4313 Belmar Ave
(If rural, give LOCATION)
4213 See informant
2.(a) If veteran, name war: V

3.(a) FULL NAME Arthur Kraeger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1887

8. AGE: Years	Months	Days	If less than one day
60	3	14	hrs. min.

9. Birthplace: Balt. Md. (Town, county, and state)
10. Usual occupation: oysterman
11. Industry or business:
FATHER 12. Name: Anthony Kraeger
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Maria Von Dorn
MOTHER 15. Birthplace: Germany
16. Informant: Mrs. Anthony Kraeger
Address: 4213 Belmar Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/1/47 (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: Baltimore, Maryland
18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY
19. April 30 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28th 19 47 at 5.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28th 19 47 to 19
and that I last saw h. in alive on at 4.00 P.M. 19

	DURATION
Immediate cause of death: Tuberculous pneumonia	3 days
Due to: Tuberculosis	6 months
Due to:	
Other conditions: bronchial asthma	18 years
psychoneurosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ike Ramm M.D. M. D. or other
Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

06885

Reg. Dist. No. 74

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 18 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3516 Meadowside Road (zone 7)
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: John Kraus

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: Rose Wendelstead

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 20, 1886

8. AGE: Years	Months	Days	If less than one day
60	10	1	..... hrs. ..... min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: clerical work

11. Industry or business:

FATHER
12. Name: John Kraus
13. Birthplace: Norfolk, Virginia

MOTHER
14. Maiden name: Louise Pick
15. Birthplace: Baltimore, Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/22/47 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore, Maryland

18. Funeral director: C. Willis Lansdeau

Address: 4510 Liberty Hts ave (7)

19. April 21 1947 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1947, at 12:15a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 14 1947, to April 21 1947

and that I last saw him alive on April 20 1947

Immediate cause of death	DURATION
Arteriosclerosis, more than	1 year
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	1 year

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.

Springfield State Hospital M. D. or other

Address: Sykesville, Maryland Date signed 4-21-47

00886

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 9 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 727 Harford Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: REBECCA MARY LEWIS

3.(b) Social Security Number: 220-07-2816

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Harvey Lewis
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): February 22, 1907

8. AGE: Years	Months	Days	If less than one day
40	2	7	...hrs. ...min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

MOTHER
12. Name: John Jones
13. Birthplace: Maryland

FATHER
14. Maiden name: Maria Teackle
15. Birthplace: Maryland

16. Informant: Mr. Harvey Lewis
Address: 727 Harford Ave.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: May 3, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.

18. Funeral director: Mrs. George B. Holland
Address: 1631 Druid Hill Ave

19. 4/29/47 (Date rec'd by registrar) Albert R. Grandstaff Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29, 1947, at 5.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20, 1947 to April 29, 1947 and that I last saw her alive on April 29, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Aug. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Wilson, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 4/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00887

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years, 19 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 11 years, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George M. Litchfield

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 17, 1876

8. AGE: Years	Months	Days	If less than one day
70	8	23	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation: Supt. of Sewerage construction
11. Industry or business: Baltimore City
FATHER 12. Name: George Litchfield
13. Birthplace: Baltimore City, Maryland
MOTHER 14. Maiden name: Actia Hildebrandt
15. Birthplace: Baltimore City, Maryland
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 14-1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Md.
18. Funeral director: George L. Schwab
Address: 701 Frederick Ave.
19. April 12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1947, at 4:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to April 10 1947 and that I last saw him alive on April 10 1947

Immediate cause of death	DURATION
General Paralysis of the Insane	17 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D. M. D. or other
Springfield State Hospital
Address: Sykesville, Maryland Date signed: 4-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

06890

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs 6 mos 20 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 18 yrs 6 mos 20 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: 3312 Walbrook Ave (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emory James Wagers.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jul 25 - 1874

8. AGE:

Years	Months	Days	If less than one day
73	1	7	hrs. ... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Dependent.

11. Industry or business:

FATHER — 12. Name: Elias J Wagers.

FATHER — 13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Emma Humphrey

MOTHER — 15. Birthplace: Baltimore

16. Interment: Wm E My Baynard

Address: 3312 Walbrook Ave Baltimore

17. Burial, cremation, or removal. Which?: Burial Date thereof: April 4 47 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville Md

18. Funeral director: Wm Tucker & Sons

Address: North & Pa Aves.

19. (Date received by registrar) 4/4 1947 City Health Dept. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2d 1947, at 10-45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1928 to April 2 1947

and that I last saw him alive on April 2d 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 da
Due to: Arteriosclerosis	20 yrs.
Due to: Epilepsy	70 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: J. J. Gaston M.D. M.D. or other

Address: Sykesville Md Date signed: 4/2/47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06888

Reg. Dist. No. 79

1. PLACE OF DEATH:

County Carroll

City or town Keymar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Keymar
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Christian Margraff

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lillie Margraff

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1874

8. AGE: Years	Months	Days	If less than one day
73	0	23	hrs. min.

9. Birthplace Accident, Garrett, Maryland
(Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business own farm

FATHER 12. Name Edward Margraff

FATHER 13. Birthplace Prussia, Germany

MOTHER 14. Maiden name Catherine Klotz

MOTHER 15. Birthplace Unknown

16. Informant Mrs. Christian Margraff

Address Keymar, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20, 1947 (month) (day) (year)

Cemetery or crematory English Lutheran Cemetery

Location Accident, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. April 17 1947 (Date rec'd by registrar) Barney M. N. Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1947, to April 16 1947, and that I last saw him alive on April 16 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Union Bridge Date signed 4-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-46M

06889

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 604 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: OTIS JAMES MERRITT

3.(b) Social Security Number: 213-01-4418

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Elizabeth Merritt
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): May 13, 1911

8. AGE:

Years	Months	Days	If less than one day
35	10	26	..... hrs. ..... min.

9. Birthplace: Raleigh, North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Henry Merritt
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Whiticut
15. Birthplace: North Carolina

18. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12, 1947 (month) (day) (year)
Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md
18. Funeral director Elroy O. Wilson
Address 1000 Bentley Ave

19. 4/8 1947 (Date rec'd by registrar) Albert R. Trunkham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1947, at 3.30PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31, 1947, to April 8, 1947 and that I last saw him alive on April 8, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Fuman, M.D.
M. D. or other
Address Henryton, Md. Date signed 4/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00891

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-47

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 13 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: P.O. Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1300 Division St. (Deanwood Park)
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CURTIS NESBITT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 15, 1944

8. AGE: Years	Months	Days	If less than one day
3	3	5	hrs. min.

9. Birthplace: Deanwood Park, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Jerome Nesbitt
13. Birthplace: Ashville, N. C.

MOTHER
14. Maiden name: Mary Robinson
15. Birthplace: Greenwood, S. C.

16. Informant: Jerome Nesbitt
Address: 5047 Lee St. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/24/47 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Wash. D. C.
18. Funeral director: W. Earl Bettes
Address: 1203 Walter St. S.E.

19. 4/20 (Date rec'd by registrar) 19 47 Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 19 47, at 12.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7, 1946 to April 20, 1947 and that I last saw him alive on April 20, 1947

Immediate cause of death	DURATION
Primary Tuberculosis	July 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Owen, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 4/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00892

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 1 mo., 24 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 yrs., 1 mo., 24 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St. Mary's

City or town: River Springs, Leonardtown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ------
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: BENSON OWENS

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): unknown About 1888

8. AGE: Years	Months	Days	If less than one day
about 59			____ hrs. ____ min.

9. Birthplace: St. Mary's County, Maryland
(Town, county, and state)

10. Usual occupation: Farmer; sailor.

11. Industry or business: ----

FATHER
12. Name: unknown
13. Birthplace:

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-7-47 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Ebert

Address: Sykesville, Md.

19. April 7 1947 (Date rec'd by registrar) C. Harry Ebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1947, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 1945, to April 5 1947

and that I last saw him alive on April 5 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2½ yrs
Due to:	
Due to:	
Other conditions: Schizophrenia, Paranoid type	25 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

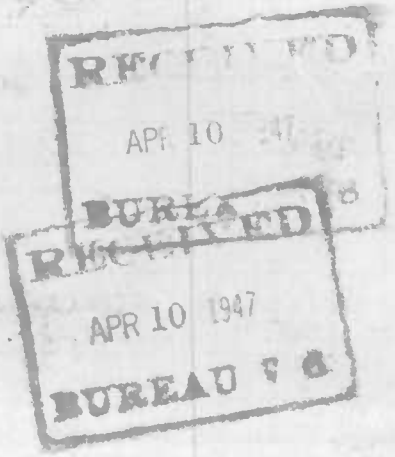
23. SIGNATURE: Arnold H. Eichert, M.D.
M. D. or other

Address: Springfield State Hospital, Sykesville, Md. Date signed: 4-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45


APR 10 1947
BUREAU
APR 10 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06893 P

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4300 Keswick Road, Baltimore-10, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME
Emily Grace Owings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William M. Owings
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8/3/1877

8. AGE: Years	Months	Days	If less than one day
69	8	20	hrs. min.

9. Birthplace: Baltimore City (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
12. FATHER Name: William MacDaniel
13. FATHER Birthplace: Baltimore
14. MOTHER Maiden name: Amanda Cover
15. MOTHER Birthplace: Baltimore
16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 4/25/47 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Baltimore, Md.
19. 4/24/47 (Date rec'd by registrar) A. D. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23, 1947, at 12:14 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/27/47 to 4/23/47
and that I last saw her alive on 4/23/47

	DURATION
Immediate cause of death: Bronchopneumonia	5 days
Due to: Generalized arteriosclerosis	?
Parkinsonism, arteriosclerotic	15 mos.
Due to: Psychosis with cerebral arteriosclerosis	16 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M.D. or other
Address: Sykesville, Maryland Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

00894

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months 17 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 8 months 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: David Phillips

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 4, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	3	..... hrs. ..... min.

9. Birthplace: Frostburg, Maryland
(Town, county, and state)

10. Usual occupation: miner

11. Industry or business

FATHER — 12. Name: Griffith Phillips

FATHER — 13. Birthplace: Wales

MOTHER — 14. Maiden name: Unk

MOTHER — 15. Birthplace: "

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-10-47 (month) (day) (year)

Cemetery or crematory: Frostburg

Location: Frostburg, Md.

18. Funeral director: J. J. Durst & Son

Address: Frostburg, Md.

19. Apr. 8 1947 (Date rec'd by registrar) C. Harry Wise Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7, 1947, at 10:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7, 1946, to April 7, 1947 and that I last saw him alive on April 7, 1947

Immediate cause of death	DURATION
Arteriosclerosis	6 yrs.
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or Other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 4/8/47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00895

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27a)

CERTIFICATE OF DEATH

Reg. Diat. No. 8W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Linwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Linwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Fannie Irene Pittinger

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~: E. U. Pittinger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 12 - 1868

8. AGE: Years: 78 | Months: 6 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Frederick County Md
(Town, county, and state)

10. Usual occupation: School teacher

11. Industry or business: Retired

FATHER
12. Name: Benjamin Echer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Mausmore
15. Birthplace: Maryland

16. Informant: E. U. Pittinger
Address: Linwood, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 5 - 1947 (month) (day) (year)

Cemetery or crematory: Beaver Dam
Location: Frederick County Md

18. Funeral director: Wm. H. Hartsock & Sons
Address: Union Bridge & New Windsor, Md

19. Apr 4 1947 (Date rec'd by registrar) Emma E. Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1947, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16 1947, to April 2 1947 and that I last saw h. alive on April 1 1947

Immediate cause of death	DURATION
Acute Cholecystitis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

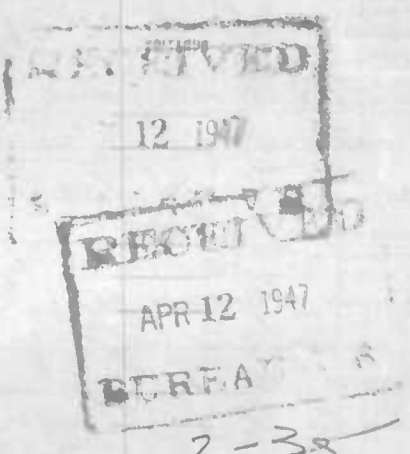
Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Bridge Date signed: 4-3-47


RECEIVED
12 1947
RECEIVED
APR 12 1947
2-38

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (88-a)

CERTIFICATE OF DEATH

00896

Reg. Dist. No. 79

PLEASE WRITE PLAINLY. WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Middleburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: near Middleburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: —
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Bessie O. Putman

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: H. Clay Putman

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 9, 1885

8. AGE: Years	Months	Days	If less than one day
62	0	16	____ hrs. ____ min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Thomas M. Wachter
13. Birthplace: Md.

MOTHER
14. Maiden name: Cynthia A. Measell
15. Birthplace: Md.

16. Informant: H. Clay Putman
Address: Middleburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28, 1947. (month) (day) (year)

Cemetery or crematory: Haugh's Mt. Zion

Location: near Ladiesburg, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19. April 28 1947 (Date rec'd by registrar) Jessie M. Nusbaum Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1947 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1947 to April 25 1947 and that I last saw h.er alive on April 24 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findiors of operatioos: ____ Date of op. ____

Aotopsy results:

PHYSICIAN: Please ooderline the caose to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: J. N. Legg M. D. or other

Address: Union Bridge Date signed 4-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

00897

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Rural Taneytown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Taneytown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Franklin P. Reaver

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Ida Hess Reaver

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 9, 1860

8. AGE: Years	Months	Days	If less than one day
87	0	26	..... hrs. ..... min.

8. Birthplace Md (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Washington Reaver

13. Birthplace Md

MOTHER 14. Maiden name Rebecca Bowers

15. Birthplace Md

16. Informant Ervin G. Reaver

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7, 1947 (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. April 7 1947 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945 to April 4 1947 and that I last saw h. alive on April 4 1947

Immediate cause of death	DURATION
Lobular Pneumonia	2 days
Due to Bronchitis	4 days
Due to	
Other conditions Chronic Bronchitis, Chronic Myocarditis (Include pregnancy within 3 months of death)	

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. S. McCaugh M. D. M. D. or other

Address Taneytown, Md. Date signed 4/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00898

Reg. Diat. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marlin E Reid

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Lola Mae Reid

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 11, 1891

8. AGE: Years 55 Months 10 Days 29 If less than one day ..... hrs. ..... min.

9. Birthplace Md

(Town, county, and state)

10. Usual occupation merchant

11. Industry or business Grocer

FATHER 12. Name John J. Reid

13. Birthplace Md

MOTHER 14. Maiden name S. May Harnish

15. Birthplace Md

16. Informant Lola M. Reid

Address Taneytown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/14/47 (month) (day) (year)

Cemetery or crematory Reformed

Location Taneytown, Md

18. Funeral director C O Buss & Son

Address Taneytown, Md

19. April 12 1947 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 2:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25, 1944 to April 10 1947

and that I last saw h.. alive on April 10 1947

	DURATION
Immediate cause of death Bronchopneumonia	4 days
Due to Progressive Muscular Atrophy	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M. D.

M. D. or other

Address Taneytown, Md Date signed 4/14/47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45

00899

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1707 Latrobe Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GLORIA AUGUSTA RICE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 12, 1921

8. AGE: Years	Months	Days	If less than one day
25	8	11	hrs. min.

9. Birthplace: Blackstone, Va.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER — 12. Name: James Rice
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Henda Jones
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 26 47 (month) (day) (year)
Cemetery or crematory: Mount Auburn
Location: Mount Auburn

18. Funeral director: Mrs. Samuel T. Hensley
Address: 578 W. Biddle St.

19. 4/23 (Date rec'd by registrar) 19 47 Albert R. Lewis Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23, 19 47, at 5.00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 19 47, to April 23 19 47 and that I last saw h...er alive on April 23, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 4/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

00900

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 yrs. 7 mon. 13 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 36 yrs. 7 mon. 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll County

City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Richard F. Richards

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE: Years: 74 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Carroll County (Town, county, and state)

10. Usual occupation: Physician

11. Industry or business:

FATHER
12. Name: D. W. Richards
13. Birthplace: Maryland

MOTHER
14. Maiden name: Saranda Boose
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 14 47 (month) (day) (year)

Cemetery or crematory: Hampstead

Location: Carroll Co. Md.

18. Funeral director: Edw. L. Tipton

Address: Hampstead Md.

19. Apr. 12 1947 C. Haney Wm (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 1947 at 9:00 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to April 12, 1947 and that I last saw him alive on April 11, 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to:	
Due to:	
Other conditions: Schizophrenia, paranoid type	38 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D., other
Address: Sykesville, Maryland Date signed: 4/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06901

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore County

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7008 Belclare Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frances Genevieve Schneider

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Otto Schneider

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 3/16/02

8. AGE: Years	Months	Days	If less than one day
45	1	14	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Pete Kafsky
13. Birthplace: Poland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Poland

16. Informant: [illegible]
Address: 7008 Belclare [illegible]

17. Burial (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: Oaklawn

Location: Eastern Ave.

18. Funeral director: Roland L. Fisher

Address: 2112 Dundalk Ave.

19. May 3 1947 (Date rec'd by registrar)

A.W. Hedrick Or A.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/30 1947, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/29/47 1947, to 4/30/ 1947 and that I last saw her alive on 4/30 1947

Immediate cause of death	DURATION
Cerebral hemorrhage (Sub-dural, right side)	5 - 6 day
Due to:	
Due to:	
Other conditions: Cirrhosis, liver	Less than 3 years

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? ...(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. (M. D. or other)

Address: Sykesville, Maryland Date signed: 5/1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06902 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45 M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 26 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 234 N. Carey Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: LLOYD SCOTT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 24, 1929

8. AGE: Years	Months	Days	If less than one day
17	6	13	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Edward Scott

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Grace Studice

15. Birthplace: North Carolina

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30 1947 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem.

Location: Baltimore, Md.

16. Funeral director: Walter R. Miller

Address: 22 N. Edmondson Ave.

19. 4/29 (Date rec'd by registrar) 19 47 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29, 1947, at 11.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 3, 1946 to Apr. 29, 1947 and that I last saw him alive on April 29, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 1st 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Walter W. Swan, M.D. M. D. or other

Address: Henryton, Md. Date signed: 4/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

06903

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: William Mathias Stansbury

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Ida V. Stansbury

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 11, 1861

8. AGE: Years	Months	Days	If less than one day
85	9	25	hrs. min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: Farmer, retired

11. Industry or business

FATHER — 12. Name: John Stansbury

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Not known

15. Birthplace: Not known

16. Informant: Mrs. Clayton Stoner

Address: Westminster, Md.

17. burial
(Burial, cremation, or removal. Which?)
Date thereof 4/7/47 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 4-7 (Date rec'd by registrar) 19 47 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1947, at 3.30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1946, to April 4 1947 and that I last saw h[illegible] alive on Apr. 4 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hours
Due to Vascular disease	5 years
Due to Senility	5 yrs
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. T. Billingslea, M.D.
M. D. or other

Address: Westminster, Md. Date signed: 4-5-47

1-35

00905

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:
County: Carroll
City or town: Keymar rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Patsy Marie Thomas | **3.(b) Social Security Number:**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	

6.(b) Name of husband or wife:
7. Birth date of deceased (mo., day, yr.): Feb 20 1947 6.(c) If alive, give age: years

8. AGE:

Years	Months	Days	If less than one day
	1	26	hrs. min.

9. Birthplace: Keymar, rural
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Carl Thomas
13. Birthplace: Carlisle, Pa
MOTHER 14. Maiden name: Clara Pittinger
15. Birthplace: Uniontown, Md.
16. Informant: Carl Thomas
Address: Keymar, Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) April 17, 1947
Cemetery or crematory: Middleburg Cemetery
Location: Middleburg, Md.
18. Funeral director: C. O. Fuss & Son
Address: Taneytown, Md.
19. (Date rec'd by registrar) April 17 1947 Registrar: Mary M. K. Powell

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1947, at 1 W. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1947, to April 16 1947
and that I last saw h.. alive on April 11 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. N. Legg, M. D. or other
Address: Union Bridge Date signed: 4-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 8-13

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: near Woodtine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural Woodtine
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: James H. Thompson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1944

8. AGE:

Years	Months	Days	If less than one day
2	4	27	hrs. min.

9. Birthplace: Baltimore City, Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: John B. Thompson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Teresa M. Greenfelder
15. Birthplace: Maryland

16. Informant: Mr. John B. Thompson
Address: Woodtine - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-3-47 (month) (day) (year)
Cemetery or crematory: St. Joseph's
Location: Sykesville Maryland
18. Funeral director: C. M. Walts
Address: Winfield, Md

19. April 2 (Date rec'd by registrar) 19 47 Edna M. Hewlett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 19 47 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—
and that I last saw h— alive on — 19—

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to: Congenital Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. Marsh, Deputy Medical Examiner M. D. or other
Address: Westminster Md Date signed: 4-2-47

1-25

00906

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Finksville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Finksville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Sykesville P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Henry Umbaugh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Mollie Arrington

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1873

8. AGE: Years	Months	Days	If less than one day
74	2	10	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Agriculture

MOTHER FATHER 12. Name Henry Umbaugh

13. Birthplace Germany

MOTHER 14. Maiden name Catherine Speilman

15. Birthplace Germany

16. Informant Mr. Sterling Umbaugh

Address Sykesville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 2, 1947 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Sykesville Md.

18. Funeral director C. Harry Wees

Address Sykesville, Md.

19. April 30 1947 C. Harry Wees

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to April 29 1947

and that I last saw h. alive on April 29 1947

Immediate cause of death	DURATION
General arterioselerotic	
cardio vascular disease	
Due to senile changes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE W. H. Lawrence, M.D.

M. D. or other

Address Sykesville Date signed 4/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46M

00907

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7X

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yr., 4 mo., 3 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 yr., 4 mo., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 119 W. Chesapeake Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Ping Tom (alias Thomas Ping)

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Chinese	married

6.(b) Name of husband or wife: Fong Tom
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): ----

8. AGE: Years	Months	Days	If less than one day
47 (?)	--	--	..... hrs. ..... min.

9. Birthplace: China (probably Canton)
(Town, county, and state)
10. Usual occupation: laundryman
11. Industry or business: Self

FATHER
12. Name: Wing Mon
13. Birthplace: China

MOTHER
14. Maiden name: Wu Sing
15. Birthplace: China

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 21, 1947 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Towson, Md.
18. Funeral director: John Burns' Sons
Address: Towson, Maryland
19. 4/21 19 47 A. W. Hedrick Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 19 47 at 12:25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to April 19 19 47
and that I last saw him alive on April 18 19 47

Immediate cause of death	DURATION
General Paralysis of the Insane	14 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 4-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45

06908

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yr., 3 mo., 4 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yr., 3 mo., d days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: York -
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Charles F. Walsh

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December, ?, 1881

8. AGE: Years	Months	Days	If less than one day
65	4	?	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: York -

11. Industry or business

FATHER
12. Name: Charles M. Walsh
13. Birthplace: Ireland

MOTHER
14. Maiden name: Elizabeth Culkin
15. Birthplace: Ireland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burnell (Burial, cremation, or removal. Which?) Date thereof: 4-30-47 (month) (day) (year)

Cemetery or crematory:
Location: Washington D.C

18. Funeral director: P. J. Gaffney
Address: 475 - 14. Street N.W.

19. April 30 1947 (Date rec'd by registrar) C. Harvey Wheel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1947 at 7:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1944 to April 29 1947 and that I last saw him alive on April 29 1947

Immediate cause of death	DURATION
Arteriosclerosis	3 yr.
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other
Springfield State Hospital
Address: Sykesville, Maryland Date signed: 4-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

00909

Reg. Dist. No. 75

M

I

T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Carroll

County .....

City or town ..... Manchester Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Manchester, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Jacob W. Warehime.

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widower.

6.(b) Name of husband or wife: Alice H Warehime

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 25, 1864

8. AGE: Years: 82 | Months: 4 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Manchester Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Manassa Warehime

13. Birthplace: Maryland

MOTHER 14. Maiden name: Elizabeth Sawyer

15. Birthplace: Virginia

16. Interment: Albert Warehime

Address: Manchester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-1-47 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Manchester Md

18. Funeral director: Jacob Wrights Sons

Address: Manchester Md.

19. Apr. 30 1947 Mrs. W. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1947 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 14 1945 to Apr. 28 1947 and that I last saw him alive on April 28 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Arterio-Sclerotic Cardio-Renal Vascular Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: — Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: — Injured at work? —

23. SIGNATURE: Jos. E. Bush Md
M. D. or other

Address: Hampstead Md. Date signed 4-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

06910

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 27 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Sudlersville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: L

3.(a) FULL NAME: John Edward Weist

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 3/16/16

8. AGE: Years	Months	Days	If less than one day
30	0	25	hrs. min.

9. Birthplace: Queen Anne's County, Md. (Town, county, and state)
10. Usual occupation: Farm Hand
11. Industry or business:
FATHER 12. Name: John Weist
FATHER 13. Birthplace: Queen Anne's County, Maryland
MOTHER 14. Maiden name: Alice Turner (Step-Mother) Mother unknown
MOTHER 15. Birthplace: Queen Anne's County, Maryland
16. Informant: Record, Springfield State Hospital
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 15 1947 (month) (day) (year)
Cemetery or crematory: Sudlersville
Location: Sudlersville Md.
18. Funeral director: Edward Pelbour
Address: Millington Md.
19. Apr. 12 1947 C. Harry Wm (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/11 1947 at 8:40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/14 1946 to 4/11 1947
and that I last saw him alive on 4/11 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1 yr.
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type (Include pregnancy within 3 months of death)	9 yrs.

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other
Address: Sykesville, Maryland Date signed: 4/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

00911

Reg. Dist. No. 77

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rachel Jane Wheeler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Joshua M Wheeler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 6 1865

8. AGE: Years 82 | Months 1 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Philip T. Hart
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah A Willhelm
15. Birthplace: Md

16. Informant: Mrs Ethel Price
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 19 47 (month) (day) (year)
Cemetery or crematory: Fairview
Location: Balto Co. Md
18. Funeral director: Edw C Lipton
Address: Hampstead Md

19. April 18 1947 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1947, at 7 30 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr. 14 1947, to April 16 1947
and that I last saw h.. alive on April 14 1947

Immediate cause of death	DURATION
Arteriosclerotic Cardio-Renal Vascular Disease	?
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Buck M.D.
M. D. or other
Address: Hampstead Md Date signed 4-16-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


APR 22
BUREAU

00912

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 40 years
Hospital, Institution, or street address where death occurred:
20 Carroll St.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll Co.
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 20 Carroll St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Leah Nora Whitmore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Paul R Whitmore
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1886

8. AGE: Years	Months	Days	If less than one day
60	4	9	...hrs. ...min.

9. Birthplace: Chambersburg, Penna.
(Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business:

FATHER
12. Name: John A Shuman
13. Birthplace: Penna.

MOTHER
14. Maiden name: Mary Horn
15. Birthplace: Penna.

16. Informant: Mr. Paul R. Whitmore
Address: 20 Carroll St. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 5 1947 (month) (day) (year)
Cemetery or ~~crematory~~: Westminster Cemetery
Location: Westminster, Md.

18. Funeral director: J. E. Myers Jr.
Address: Westminster. Md.

19. 4/4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1947, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14 1942, to April 3 1947
and that I last saw her alive on April 2 1947

Immediate cause of death	DURATION
Carcinoma Left Parotid Gland	2 yrs.
Due to	
Due to	
Other conditions: Diabetes mellitus	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other
Address: Westminster Md. Date signed: 4/4/47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

00913

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CHARLES HENRY WILLIAMS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife Edna Florence Williams
B.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 20, 1897

8. AGE: Years	Months	Days	If less than one day
49	9	4	....hrs. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/27/47 (month) (day) (year)
Cemetery or crematory Piney Grove
Location Baltimore Co Md
18. Funeral director Edw A Tipton
Address Hampstead Md

19. 4/24 (Date rec'd by registrar) 1947 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1947, at 3.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb., 26, 1947 to April 24, 1947 and that I last saw him alive on April 24, 1947

Immediate cause of death Pulmonary Tuberculosis — DURATION June 1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Reuben H Swan, M.D. M. D. or other
Address Henryton, Md. Date signed 4/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-43 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06914

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 19 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 705 Vine Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME EDNA WILLIAMS

3.(b) Social Security Number 218-12-4889

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 3, 1920

8. AGE: Years 26 | Months 5 | Days 23 | If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Oscar Williams
13. Birthplace Unknown

MOTHER
14. Maiden name Annie Sample
15. Birthplace Virginia

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/30/47 (month) (day) (year)
Cemetery or crematory Mt Auburn Cem
Location

18. Funeral director Mrs Samuel T. Hemsley
Address 578 W. Biddle Street.

19. 4/26 (Date rec'd by registrar) 19 47 Albert R. Grantham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 19 47 at 8.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7, 19 46 to April 26, 19 47 and that I last saw her alive on April 26, 19 47

Immediate cause of death Pulmonary Tuberculosis — DURATION Jan. 1946
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ruben W. Duncan, M. D.
M. D. or other
Address Henryton, Md. Date signed 4/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-47 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22d)

CERTIFICATE OF DEATH

00315

Reg. Dist. No. 79

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Carroll

City or town Bruceville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Bruceville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Annie Catherine Wilson

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife John R. Wilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 15, 1882

8. AGE:

Years	Months	Days	If less than one day
64	9	21	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles Stitely

13. Birthplace Md

MOTHER 14. Maiden name Martha Welty

15. Birthplace Md

16. Informant John R. Wilson

Address Keymar, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8, 1947 (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19 April 7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1947, at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1947, to April 5 1947 and that I last saw h alive on April 2 1947

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs.
Due to Chronic Endocarditis probably involving all valves,	7 yrs.
Due to Cause unknown	
Other conditions Chronic Bronchitis	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McWaine M. D. M. D. or other

Address Taneytown, Md. Date signed 4/5/47

00916

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years, 5 months, 21 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 15 years, 5 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Helen Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 12, 1872

8. AGE: Years	Months	Days	If less than one day
74	6	30	..... hrs. ..... min.

8. Birthplace: Annapolis, Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: George Jacobi

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Ellen Hughes

MOTHER 15. Birthplace: Ireland

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-14-47 (month) (day) (year)

Cemetery or crematory: St Anns Cemetery

Location: Annapolis, Md.

18. Funeral director: John M Taylor

Address: Annapolis, Md.

19. April 12 19 47 C. Harry Elsey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1947 at 9.30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1942 to April 11 1947 and that I last saw her alive on April 11, 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	10 days
Due to arteriosclerosis	12 years
Due to	
Other conditions: Involutional psychosis	16 years

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Irene Hickman M.D.
M. D. or other

Address: Springfield State Hospital Date signed: 4-11-47

00917

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 24 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1712 Madison Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MABEL ELIZABETH WONSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Linwood Wonson
6.(c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) December 20, 1920

8. AGE: Years	Months	Days	If less than one day
26	3	12	....hrs. ....min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name James Iverson
13. Birthplace Virginia
MOTHER 14. Maiden name Mary Cook
15. Birthplace Virginia
16. Informant Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-5-47 (month) (day) (year)
Cemetery or crematory Warsaw
Location Va.
18. Funeral director Geo. G. Kelsow
Address 1303 Prestman. St.
19. 4/1 (Date rec'd by registrar) 19 47 Albert R. Swanbourg Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1947 at 4.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7, 1946 to April 1, 1947 and that I last saw her alive on April 1, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address Henryton, Md. Date signed 4/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-46 5M

2-40 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00918

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Paul E. Zahn

3.(b) Social Security Number: 216-07-4182

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Stella J. Zahn
6.(c) If alive, give age: 51 years
7. Birth date of deceased (mo., day, yr.): August 19, 1891

8. AGE: Years	Months	Days	If less than one day
55	7	20	...hrs. ...min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Restaurant
FATHER 12. Name: John L. Zahn
13. Birthplace: Maryland
MOTHER 14. Maiden name: Eliza Hanley
15. Birthplace: Maryland
16. Informant: Mrs. Paul E. Zahn
Address: Westminster, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof 4/10/47 (month) (day) (year)
Cemetery or crematory: Krider's Cemetery
Location: Near Westminster, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 4/9 (Date rec'd by registrar) 19 47 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 19 47 at 7:45 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 8 19 47 to Apr 8 19 47 and that I last saw h... alive on Apr 8 19 47

Immediate cause of death	DURATION
General arteriosclerosis	
Myocardial failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Westminster Md. Date signed 4-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING
VS A15